FORMULAS AND INSTRUCTIONS FOR USE OF SERVICES MEASURES

The following formulas are used throughout the remaining part of the Use of Services domain. Where indicated, these formulas should be adjusted for age and sex stratification.

Note: These formulas are adapted from the Minnesota Utilization Data Definitions Committee's Reporting Standards for Health Care Utilization Data, February, 1992.

Age of Members

Unless otherwise specified, report member age as of the date of service. If the service is an inpatient admission, use age as of the date of discharge.

Average Length of Stay

Total days/total discharges.

Discharges

Total discharges associated with (a) particular diagnosis code(s).

Member Months

The sum of the enrollment in the health plan for each month during the reporting year (i.e., the sum of the 12 monthly membership totals).

See also the Health Plan Descriptive Information domain for instructions on the calculation of member months.

Member Years

Member years serve as a proxy for annual membership and are calculated as:

X member months/12 months = Y member years.

Discharges per 1,000 Member Months

(Total discharges/member months) x 1,000

Discharges per 1,000 Members per Year

(Total discharges/member months) x 1,000 x 12

Discharges per 1,000 Female Member Months, stratified

For all tables in this chapter that are stratified by age (or by age and sex), rate per 1,000 member months means:

Member months within the particular age and sex category specified in each row of the table e.g., [(total discharges for female members age 20 through 34 years) ÷ (member months of female members age 20 through 34 years)] x 1,000

Discharges per 1,000 Female Members per year, stratified

For all tables in this chapter that are stratified by age (or by age and sex), rate per 1,000 members per year means:

Members within the particular age and sex category specified in each row of the table e.g., [(total discharges for female members age 20 through 34 years) ÷ (member months of female members age 20 through 34 years)] x 1,000 x 12

Length of Stay (LOS)

If all days are approved, the LOS is the number of days from admission to discharge; the last day of the stay is not counted, unless the admission and discharge date are the same.

LOS = Discharge date – Admit date

If some of the days are denied, the length of stay is the number of days from admit to discharge, not counting the last day of the stay, less the number of denied days:

LOS = Discharge date – Admit date – Denied days.

Note: *When an inpatient revenue code (a UB-92 or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admit date are the same, then the discharge date minus admit date equals one day, not zero. Adjust the LOS accordingly.*

Total Days Incurred

The sum of the length of stay for all discharges during a reporting year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days. Total days include days that occur before January 1 of the reporting year for discharge dates occurring during the reporting year.

Total Days Incurred = sum of LOS for each discharge during the reporting year.

Total Days Incurred per 1,000 Members per Year

(Total days incurred/member months) x 1,000 x 12.

Notes

- A table reporting member months per age category (and sex category, if required) is provided with each Use of Services table. Member months per each category is used as the denominator to calculate use of services rates reported in each table.
- Continuous enrollment requirements apply to the following measures:

  Readmission for Specified Mental Health Disorders (Table 5L) and Readmission for Chemical Dependency (Table 5O).
- For all measures in which the specifications offer plans the option of using a DRG, the use of DRG codes is preferred. If DRGs are unavailable, plans should use the other specified methods (e.g., ICD-9-CM codes).
- The following measures were originally adopted from the Minnesota Utilization Data Definitions Committee's Standards for Health Care Utilization Data; February 1992: Inpatient Utilization — General Hospital/Acute Care; Ambulatory Care; Discharge and Average Length of Stay — Maternity Care; Cesarean Section Rate and Vaginal Birth after Cesarean Section Rate (VBAC-Rate); Mental Health Utilization — Inpatient Discharges and Average Length of Stay; Mental Health Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services; Readmission for Selected Mental Health Disorders; Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay; Chemical Dependency Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services; Readmission for Chemical Dependency.

Stratification by Payer/Eligibility Category

Members enrolled in a health plan who are covered by different payers tend to vary considerably by sociodemographic characteristics, average time of enrollment and utilization patterns. For this reason, Use of Services tables will be reported separately for each payer (i.e., Medicaid, commercial and Medicare risk). For Medicaid members only, the Use of Services tables should be reported by eligibility category.

Throughout the Use of Services domain, tables are designated as follows:

Table 1a	Total Medicaid
Table 1b	Medicaid/Medicare Dual Eligibles
Table 1c	Medicaid — Disabled
Table 1d	Medicaid — Other Low Income
Table 2a	Commercially Enrolled — Health Plan Wide (for each product type)
Table 2b	Commercially Enrolled — Employer/Purchaser Specific
Table 3	Medicare Risk

Medicaid enrollees: Refer to the Health Plan Descriptive Information domain for a definition of the Medicaid eligibility categories. Note that Medicaid enrollees in Category 1 (limited benefit package) are not reported separately, but included in Table 1a (Total Medicaid). The sum of Table 1b (Dual Eligibles), 1c (Disabled) and 1d (Other Low Income), therefore, does not equal Table 1a (Total Medicaid).

Information on the categorization of Medicaid enrollees is to be provided to the health plan by the state. If a state does not provide this data, the health plan may report "Total Medicaid" only.

Dual eligibles should be reported in Table 1a (Total Medicaid) and Table 1b (Medicaid/Medicare Dual Eligibles) regardless of the kind of Medicare coverage. Dual eligibles should be reported in Table 3 (Medicare Risk) if the health plan holds a Medicare risk contract. Medicaid/Medicare risk dual eligibles will, therefore, be counted both under Medicaid and Medicare.

Commercial enrollees: Both "direct pay" and "group" enrollees should be reported as commercial enrollees. Table 2a (Health Plan Wide — for each product type) reports on all of the plan's commercial enrollees. Table 2b (Employer/Purchaser Specific) reports only on the enrollees covered by a particular employer or purchaser.

Because utilization patterns vary with population characteristics, there is no "total" Use of Services table summarizing information on all enrolled health plan members.

Use of Services tables will have up to seven versions (i.e., 1a, 1b, 1c, 1d, 2a, 2b and 3). Complete only the tables relevant to the plan (i.e., tables reflecting the populations for whom the plan serves).

Use of Services data should be reported on the basis of **member years** for commercial and Medicare risk members and on the basis of **member months** for Medicaid members (this acknowledges that Medicaid beneficiary enrollment in managed care tends to be less stable than enrollment of commercial or Medicare members).

Unless otherwise specified, a plan member should be assigned to a category based on his/her payer and, for Medicaid members, on type of eligibility on the date of service.

If the service is an inpatient admission, use the payer/type of eligibility category as of the member's discharge date.

For individuals who are enrolled in more than one payer group during the reporting year, count the number of months attributable to each payer in the respective table.

Report age as of the date of service for the Use of Services measures. For inpatient admissions, report age as of the date of discharge.

Stratification by Age

Because of the demographic characteristics of the Medicaid and Medicare risk populations, most Use of Services tables have more detailed age categories, especially for children and for members age 65 years or older.

For Commercial Reporting: When a Use of Services table requests a non-percentage rate (e.g., discharges per 1,000 members) and a plan's total enrollment for the table is less than 1,000, the plan should not report the table. This applies to both plan-wide and employer-specific reporting. If the enrollment in a particular age/sex category is less than 30, plans should suppress the reporting (i.e., leave the cell blank) for that category. The same recommendation applies if a Use of Services table requests a percentage, and a plan's enrollment in a particular age/sex category (i.e., the denominator) is less than 30. When tables contain fewer than 30 members for a particular age and/or sex category, health plans should report only the "Total" or "Grand Total" for the indicator. (For example, a health plan reporting mental health inpatient discharges for an

employer group finds that of the 34 males receiving inpatient mental health services, 14 are between 13-17 years of age and 20 are between 18-64 years of age. In the employer specific table, the plan should report only that 34 Total Males received inpatient mental health services.)

For Medicaid and Medicare Risk Reporting: When reporting Use of Services tables for the Medicaid and Medicare Risk populations, if the enrollment in a particular age/sex category is less than 30, plans should report the number (numerator) of events of interest (e.g., newborns, discharges, surgeries/procedures, days) but not calculate the requested rate.

If a Use of Services table requests a percentage and a plan's enrollment in a particular age/sex category (i.e., the denominator) is less than 30 plans should report the number (numerator) of events of interest, but not calculate the percentage.

Calculating rates based on numbers below these thresholds is not advisable, and small numbers should not be used for plan-to-plan comparison. States and HCFA will (if they desire) be able to calculate rates for Medicaid and Medicare members using the numerator data in conjunction with member months in each age/sex category provided with each utilization table. This allows states and HCFA to aggregate these data with those of other managed care plans to produce statewide or national data.

FREQUENCY OF SELECTED PROCEDURES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *For commercial members, three procedures have been added.*
- ➤ *Coding has been updated.*

Description

This measure provides a summary of the number and rate of several frequently performed procedures. These procedures often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Specifications

Calculation: This measure should be reported separately by payer (i.e., Medicaid, commercial and Medicare risk). For Medicaid members, report the absolute number of procedures and the number of procedures per 1,000 Member Months. For commercial and Medicare risk members, report the absolute number of procedures and the number of procedures per 1,000 Members per Year.

Note: *If, for the same procedure, two or more codes appear on the same date of service for the same patient, the procedure should count once (e.g., CPT-4 code 47610 and CPT-4 code 47620 on July 10, 199X, on the same patient would count once toward the number of cholecystectomies; ICD-9-CM code 60.21 and CPT-4 code 52630 on May 3, 199X, on the same patient would count once toward the number of prostatectomies.)*

Medicaid: Table 5C-1a reports the total number of procedures and the rate of procedures per 1,000 Member Months, by age and sex.

Note: *This measure is reported only for Total Medicaid. Reporting this information by Medicaid eligibility category would result in small numbers.*

Commercial: Tables 5C-2a and 5C-2b are constructed using Table 5C-2 as a template. Report the total number of procedures and the rate of procedures per 1,000 Members per Year for the appropriate age and sex categories.

Medicare: Table 5C-3 reports the total number of procedures and the rate of procedures per 1,000 Members per Year for Medicare risk members.

Table 5B: Codes

These classification codes are used to identify the procedures reported in Tables 5C-1a, 5C-2a-b, 5C-3

Procedure	ICD-9-CM Procedure Codes	CPT-4 Codes
Myringotomy: (Myringotomy or Myringotomy with Adenoidectomy) *Medicaid and Commercial* Males, Females, Age 0-4 Males, Females, Age 5-19	20.01	69433, 69436
Tonsillectomy: (Tonsillectomy or Tonsillectomy with Adenoidectomy) *Medicaid and Commercial* Males, Females, Age 0-9 Males, Females, Age 10-19	28.2, 28.3, 28.4	42820, 42821, 42825, 42826, 42860
Non-Obstetric Dilation and Curettage: *Medicaid and Commercial* Females, Age 15-44 Females, Age 45-64	69.09	58120
Hysterectomy: *Medicaid and Commercial* Females, Age 15-44 Females, Age 45-64 *Medicare risk* Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	68.3, 68.4, 68.5, 68.51, 68.59, 68.6, 68.7, 68.8, 68.9	56308, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58951, 59135, 59525
Cholecystectomy: open and closed (laparoscopic) cholecystectomy reported separately *Medicaid and Commercial* Males, Age 30-64 Females, Age 15-44 Females, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	**open:** 51.21, 51.22 **closed (laparoscopic):** 51.23, 51.24	**open:** 47600, 47605, 47610, 47612, 47620 **closed (laparoscopic):** 56340, 56341, 56342
Laminectomy/Diskectomy: *Commercial* Male, Age 20-64 Female, Age 20-64	03.02, 03.09, 80.50, 80.51, 80.59	22220, 22222, 22224, 22226, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091
Angioplasty (PTCA): *Commercial* Males, Age 45-64 Females, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	36.01, 36.02, 36.05	92982, 92995, 92980, 92981, 92984, 92996
Cardiac Catheterization: *Commercial* Males, Age 45-64 Females, Age 45-64	37.21-37.23, 88.55, 88.56, 88.57	93501, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93539, 93540, 93543, 93544, 93545, 93541, 93542

Table 5B: Continued

Procedure	ICD-9-CM Procedure Codes	CPT-4 Codes
Coronary Artery Bypass Graft: *Commercial* Males, Age 45-64 Females, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17, 36.19, 36.2	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33572
Prostatectomy: *Commercial* Males, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+	60.21, 60.29, 60.3, 60.4, 60.5, 60.61, 60.62, 60.69	52601, 52612, 52614, 52620, 52630, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 52647, 52648
Reduction of Fracture of Femur: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	79.05, 79.15, 79.25, 79.35	27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248
Total Hip Replacement: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	81.51	27130, 27132, 27134
Total Knee Replacement: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	81.54	27446, 27447
Partial Excision of Large Intestine: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	45.7x	44140, 44141, 44143, 44144, 44145, 44146, 44147
Carotid Endarterectomy: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	38.12	34001, 35001, 35301, 35501, 35601, 35390

Notes

➤ Procedures can be identified using either the specified ICD-9-CM or CPT-4 codes. Health plans should report counts for the procedures as specified. All procedures should be included in the count regardless of the site of care. For example, include myringotomies performed in ambulatory and inpatient settings. The total number of procedures should be reported rather than the number of members who received the procedure.

Myringotomy:

- The measure intends to measure the frequency of "Myringotomy with tube replacement".
- This measure includes Myringotomies or Myringotomies and Adenoidectomies. Adenoidectomies performed alone do not count towards this measure.
- ICD-9-CM code 20.09 and CPT-4 codes 69420 and 69421 do not count towards this measure.
- Myringotomy and Tonsillectomy occurring on the same date of service count toward both measures.

Tonsillectomy:

- Tonsillectomy or Tonsillectomy and Adenoidectomy count towards this measure; Adenoidectomy performed alone does not count towards this measure.
- Myringotomy and Tonsillectomy occurring on the same date of service count toward both measures.

Non-Obstetric Dilation and Curettage:

- This category does not include obstetric D&C or termination of pregnancy D&C.
- ICD-9-CM codes 69.01 and 69.02 and CPT-4 code 57820 do not count toward this measure.
- A non-obstetric D&C performed in conjunction with (i.e., on the same date of service as) a hysterectomy should not be counted in the D&C rate; count only the hysterectomy.

Cholecystectomy:

- Report open and closed (laparoscopic) cholecystectomy separately.

Laminectomy/Diskectomy:

- This measure is intended to capture disk surgeries. For this reason, CPT-4 codes relating to laminectomies without disk removal are excluded.

Cardiac Catheterization:

- A cardiac catheterization performed in conjunction with (i.e., on the same date of service as) an angioplasty should not be counted in the cardiac catheterization rate; count only the angioplasty.

CABG:

- Regardless of the number of arteries involved or the number or types of grafts involved, count each CABG procedure only once for each date of service per patient.

Carotid Endarterectomy:

- CPT-4 code 35002 does not count toward the measure; it does not relate to an elective procedure.

➤ For Medicaid members, dilation and curettage procedures and tonsillectomy procedures with or without adenoidectomy (excludes isolated adenoidectomies) were included because geographic variation in the frequency of their performance was found. Myringotomy with or without adenoidectomy (excludes isolated adenoidectomies) was also added because this procedure addresses otitis media, a condition very common in children.

Table 5C-1a: Frequency of Selected Procedures: Medicaid

Age	Member Months		
	Male	Female	Total
0-4			
0-9			
5-19			
10-19			
15-44			
30-64			
45-64			

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Member Months
Myringotomy	0-4	Male and Female		
	5-19	Male and Female		
Tonsillectomy Adenoidectomy	0-9	Male and Female		
	10-19	Male and Female		
Dilation & Curettage	15-44	Female		
	45-64	Female		
Hysterectomy	15-44	Female		
	45-64	Female		
Cholecystectomy, open	30-64	Male		
	15-44	Female		
	45-64	Female		
Cholecystectomy, closed (laparoscopic)	30-64	Male		
	15-44	Female		
	45-64	Female		

Template Table 5C-2: Frequency of Selected Procedures: Commercial

Age	Member Months: Male	Female	Total
0-4			
0-9			
5-19			
10-19			
15-44			
20-64			
30-64			
45-64			

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
Myringotomy	0-4	Male and Female		
	5-19	Male and Female		
Tonsillectomy Adenoidectomy	0-9	Male and Female		
	10-19	Male and Female		
Dilation & Curettage	15-44	Female		
	45-64	Female		
Hysterectomy	15-44	Female		
	45-64	Female		
Cholecystectomy, open	30-64	Male		
	15-44	Female		
	45-64	Female		
Cholecystectomy, closed (laparoscopic)	30-64	Male		
	15-44	Female		
	45-64	Female		
Laminectomy Diskectomy	20-64	Male		
	20-64	Female		
Angioplasty (PTCA)	45-64	Male		
	45-64	Female		
Cardiac Catheterization	45-64	Male		
	45-64	Female		
CABG	45-64	Male		
	45-64	Female		
Prostatectomy	45-64	Male		

Table 5C-3: Frequency of Selected Procedures: Medicare Risk

	Member Months		
Age	**Male**	**Female**	**Total**
< 65			
65-74			
75-84			
85+			

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
CABG	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Angioplasty (PTCA)	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Carotid Endarterectomy	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		

Table 5C-3: Continued

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
Reduction of Fracture of Femur	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total Hip Replacement	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total Knee Replacement	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Partial Excision of Large Intestine	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		

Table 5C-3: Continued

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
Cholectystectomy, Open	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Cholecystectomy, Closed (laparoscopic)	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Hysterectomy	< 65	Female		
	65-74	Female		
	75-84	Female		
	85+	Female		
Prostatectomy	< 65	Male		
	65-74	Male		
	75-84	Male		
	85+	Male		

INPATIENT UTILIZATION — GENERAL HOSPITAL/ACUTE CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *Age stratification is more detailed for children and for members age 65 years and older, to account for demographic characteristics of the Medicaid and Medicare populations.*
- *Newborns are no longer reported in this measure; however, the Births and Average Length of Stay, Newborns measure was modified so that newborn utilization rates can be added to utilization rates reported in this measure.*
- *Medical and surgical services are reported separately.*
- *In addition to reporting Days and Discharges, health plans are asked to report Discharges/1,000 Member Months and Days/1,000 Member Months for Medicaid members, and Discharges/1,000 Members per Year and Days/1,000 Members per Year for commercial and Medicare risk members.*

Description

This table summarizes utilization of acute inpatient services in the following categories: total services, medicine, surgery and maternity. Nonacute care, mental health and chemical dependency services, as well as newborns, are excluded.

Specifications

Calculation:

Medicaid: Tables 5D-1a, 5D-1b, 5D-1c and 5D-1d are constructed using Table 5D-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days, Days/1,000 Member Months and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: 5D-2a, 5D-2b and 5D-3 are constructed using Table 5D-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days, Days/1,000 Members per Year and Average Length of Stay for the members in the payer group that each table addresses.

Total general hospital/acute care services should exclude mental health and chemical dependency, as well as newborns, all of which are reported separately. Gynecology and pediatric care should be reflected in the medicine and surgery categories as appropriate. Observation stays that result in inpatient admission should be counted in the appropriate category in this measure.

For inpatient utilization, identify discharges designated as "inpatient" by the Type of Bill code (Form Locator 4) on the UB-92 billing form:

11X = Hospital Inpatient (Including Medicare Part A)

OR

41X = Christian Science Hospital Inpatient (Including Medicare Part A)

OR

12X = Hospital Inpatient (Medicare Part B only)

OR

42X = Christian Science Hospital Inpatient (Medicare Part B only) where X represents any third digit.

Total: Total Inpatient excludes nonacute care, mental health, chemical dependency and newborns. The total should represent the sum of the three categories (medicine, surgery and maternity).

DRG codes: 1-108, 110-384, 392-423 and 439-473, 475-494

OR

ICD-9-CM codes: All principal diagnosis codes excluding 290.x-315.xx, 316, 965.0x, 965.8x, 967.xx, 968.5x and 969.xx, also any inpatient discharged with any ICD-9-CM diagnosis code of V30.x-V39.x.

Maternity: Include all inpatient hospitalizations for maternity-related reasons, including abortions and antepartum stays.

Use the following diagnosis codes to identify obstetrics discharges:

DRG codes: 370-384

OR

ICD-9-CM codes: Principal diagnosis codes 630-676.94 and V24.0

OR

UB-92 Occurrence Code (Form Locator 32-35): Medical Condition Code: H 10

Note: Birthing center deliveries should be included in this measure and be counted as one day of stay.

We recognize that the "V" diagnosis codes V22.x, V23.x, V27.x and V61.5-V61.7 are not correct codes for principal OB inpatient diagnoses, where "x" equals any fourth digit. However, if these codes are present in the inpatient database, report them in this category.

UB-92 Occurrence Code H10 is a medical diagnosis code indicating the last menstrual period, which only applies when the patient is being treated for maternity related conditions.

Surgery:

DRG codes: 1-8, 36-42, 49-63,75-77, 103-108, 110-120, 146-171, 191-201, 209-234, 257-270, 285-293, 302-315, 334-345, 353-365, 392-394, 400-402, 406-408, 415, 439-443, 458, 459, 461, 468, 471, 472, 476-486, 488, 491, 493, 494

OR

ICD-9-CM principal diagnosis codes: When ICD-9-CM codes are used to identify the patients receiving surgical services, it is best to do so by first identifying the "total" above and then removing maternity. The remainder represents medicine/surgery. Identify hospitalizations for surgical care as those who are assigned:

UB-92 Revenue code (Form Locator 42): 36X (Operating Room Services), where X represents any third digit.

Medicine:

DRG codes: 9-35, 43-48, 64-74, 78-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 395-399, 403-405, 409-414, 416-423, 444-457, 460, 462-467, 473, 475, 487, 489, 490, 492

OR

ICD-9-CM principal diagnosis codes: When ICD-9-CM codes are used to identify the patients receiving medical services, it is best to do so by first identifying the "Total" above and then removing maternity. The remainder represents medicine/surgery.

Identify hospitalizations for medical care as those who are <u>not</u> assigned:

UB-92 Revenue code (Form Locator 42): 36X (Operating Room Services), where X represents any third digit.

Notes

- The DRGs in this measure were adopted from Diagnosis Related Groups, Version 10.0, Definitions Manual.
- DRGs 109, 438, and 474 are no longer valid and should not be reported.
- DRGs 469 (principal diagnosis invalid as discharge diagnosis) and 470 (ungroupable) should be counted in the "Total" category only, but not in the categories "Medicine" and "Surgery."
- Regardless of the methodology employed by the health plan to document surgeries, the plan is responsible for verifying how surgeries are being identified.
- Medical and surgical services are reported separately because the factors influencing utilization in these two categories vary. This also enables easier comparisons between ambulatory surgery utilization (refer to the Ambulatory Care measure) and inpatient surgery utilization.

Template Table 5D-1: Inpatient Utilization — General Hospital/Acute Care: Medicaid

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Member Months	Average Length of Stay
Total Inpatient					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Medicine					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Surgery					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Maternity					
10-19					
20-44					
45-64					
Unknown					
Total					
Total Member Months					

Template 5D-2/3: Inpatient Utilization — General Hospital/Acute Care: Commercial and Medicare Risk (reported separately)

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges / 1,000 Members	Days	Days / 1,000 Members	Average Length of Stay
Total Inpatient					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Medicine					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Surgery					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Maternity					
10-19					
20-44					
45-64					
Unknown					
Total					
Total Member Months					

AMBULATORY CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *Observation room stays are counted separately.*
- *Age stratification is more detailed for children and for members age 65 years and older to account for demographic characteristics of the Medicaid and Medicare risk populations.*

Description

This table summarizes utilization of ambulatory services in the following categories: Outpatient Visits (excluding mental health and chemical dependency), Emergency Room Visits, Ambulatory Surgery/Procedures performed in hospital outpatient facilities or freestanding surgical centers, and Observation Room Stays that result in discharge (Observation Room Stays resulting in an inpatient admission are counted in the Inpatient Utilization — General Hospital Acute Care measure.

Specifications

Calculation:

Medicaid: Tables 5E-1a, 5E-1b, 5E-1c and 5E-1d should be constructed using Table 5E-1 as a template. Report Outpatient Visits, Emergency Room Visits, Ambulatory Surgery Procedures, Observation Room Stays and the respective rates /1,000 Member Months for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5E-2a, 5E-2b and 5E-3 should be constructed using Table 5E-2/3 as a template. Report Outpatient Visits, Emergency Room Visits, Ambulatory Surgery Procedures, Observation Room Stays and the respective rates/1,000 Members per Year for members in the payer group that each table addresses.

Outpatient Visits (Evaluation and Management Services)

This category accounts for face-to-face encounters between the practitioner and patient and provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all inclusive. Only those plans with administrative data systems may be able to calculate this measure.

Instructions:

- Report services without regard to type of provider/practitioner or the provider's/practitioner's training or licensing.
- Encourage detailed service reporting, even when the financial reimbursement arrangement does not require it, in order to facilitate comparability and complete reporting.

- Include after-hours, non-emergency urgent care.
- Include nursing home visits.
- Omit surgical procedures, regardless of location of service (these are captured in the ambulatory surgery/procedures tables).
- Exclude services coded as primarily pertaining to mental health or chemical dependency.
- Count each member with an occurrence of a CPT-4 procedure code in the following ranges:

Office or Other Outpatient Services:	
New Patient	99201-99205
Established Patient	99211-99215
Consultations	99241-99245
Home Services:	
New Patient	99341-99343
Established Patient	99351-99353
Prolonged Services:	
Prolonged Physician Services	99354-99355
Comprehensive Nursing Facility Assessments:	99301-99303
Subsequent Nursing Facility Care:	99311-99313
Domiciliary, Rest Home or Custodial Care Services:	
New Patient	99321-99323
Established Patient	99331-99333
Case Management Services:	
Team Conferences	99361-99362
Telephone Calls	99371-99373
Preventive Medicine:	
New Patient	99381-99387
Established Patient	99391-99397
Individual Counseling:	99401-99404
Group Counseling:	99411-99412
Other	99420-99429
Newborn Care:	99432

Other Evaluation and Management Services:

99499

Ophthalmology and Optometry:

92002-92014

Note: In states that use a state-level HCPCS code to identify refractions provided by ophthalmologists and optometrists, these services should also be included. If the plan does not use HCPCS or CPT-4 codes, develop a methodology to count all face-to-face encounters with the following practitioners: primary care physicians, specialists, nurse practitioners, physician assistants, ophthalmologists and optometrists.

Emergency Room Visits

This category measures use of ER services, which are included because they may sometimes be used as a substitute for ambulatory clinic encounters. While patient behavior is a factor in the decision to use an ER rather than a clinic or physician's office, the decision may be a result of insufficient access to primary care. Therefore, trends in ER utilization are an important aspect of total utilization data.

Instructions:

- Each visit to an ER that does not result in an inpatient stay should be counted once, regardless of the intensity of care required during the stay or the length of stay. Patients admitted to the hospital from the ER should not be included in counts of visits. Only visits to emergency rooms should be counted; visits to urgent care centers should not be counted in this measure.
- The unit counted is an "Emergency room visit," which should be identified by:

  UB-92 Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" represents any third digit in this code.

  AND

  UB-92 "Revenue" code (Form Locator 42): 45X (Emergency Room) where "X" represents any third digit in this code,

OR

HCFA 1500 Place of Service code (Item 24b): 23 (Emergency Room)

AND

CPT-4 codes: 10040-69979 or 99281-99288

Ambulatory Surgery/Procedures:

This is an important category to include in ambulatory reporting because many procedures formerly performed during an inpatient stay now are routinely performed on an outpatient basis. Some hospitals have developed large ambulatory surgery centers, and independent surgical centers have been built to accommodate this trend. New technology makes it increasingly possible to perform more complex surgery in ambulatory settings, and a growing number of procedures are performed at a physician's office. However, surgeries/procedures performed in physicians' offices are excluded from this measure.

Instructions:

- Only Ambulatory Surgery/Procedures performed at a hospital outpatient facility or at a freestanding surgery center should be reported. Office-based surgeries/procedures should not be reported.
- The unit counted is an "Ambulatory Surgery/Procedure Encounter," defined as one discrete service date for a specific member at a specific site (regardless of the number of services provided at that site) on that day, for that member.
- Claims with ER revenue codes (Form Locator 42) of 450 or 459 should be excluded from this category and reported under "Emergency Room Visit."
- This category includes surgical procedures, scopics/lithotripsy and heart procedures.
- "Ambulatory Surgery/Procedure Encounters" are identified using two options: Option A (the HCFA 1500) or Option B (the UB-92). Specify which option your plan implements.

  HCFA 1500 Place of Service code (Item 24b): 22 (outpatient hospital) or 24 (ambulatory surgical center)

  AND

  CPT-4 code: All codes included in the HCFA Ambulatory Surgical Center (ASC) Base Eligibility File, 92953, 92970, 92971, 92975, 92980, 92982, 92986, 92990, 92992, 92993, 92995, 93501-93536, 93600-93652.

  Note: The HCFA ASC Base Eligibility File is available through the Bureau of Data Management and Strategy at (410) 786-3691.

OR

UB-92 Type of Bill code (Form Locator 4): 13X (Hospital outpatient), 43X (Christian Science hospital outpatient) or 83X (Specialty facility outpatient), where "X" represents any third digit in this code.

AND

UB-92 Revenue code (Form Locator 42):

36X (Operating room services),

49X (Ambulatory surgical care),

75X (Gastrointestinal services),

79X (Lithotripsy),

480 (Cardiology general classification),

481 (Cardiac cath lab),

320 (Radiology-diagnostic general classification),

321 (Angiocardiography) or

323 (Arteriography),

where "X" represents any third digit in this code.

AND

ICD-9-CM procedure codes: Codes 01.0 through 86.99, 88.42, 88.50-88.58 or 98.51-98.59.

Note: *Use of the HCFA 1500 and CPT-4 codes is the preferred method for this measure. When it is necessary for the plan to use both methods (i.e., the HCFA 1500 and the UB-92), the plan is responsible for avoiding double-counting.*

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Observation room stays are increasingly used to determine whether the condition of a patient necessitates inpatient admission. Trends in utilization of observation rooms are an important aspect of total utilization data.

Instructions:

- Each stay in an observation room that does not result in an inpatient stay should be counted once, regardless of the intensity of care required during the stay or the length of time spent. Patients admitted to the hospital from the observation unit (whose observation unit stay would be billed on an inpatient bill) should not be included this measure.
- Claims with ER revenue codes (Form Locator 42) of 450 or 459 should be excluded from this category and reported under "Emergency Room Visits." Claims with Ambulatory Surgery revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321 or 323) should be excluded from this category and reported under "Ambulatory Surgery/Procedures."
- The unit counted is an "Observation room stay," which should be identified by:

  UB-92 Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" represents any third digit in this code.

  AND

  UB-92 Revenue code (Form Locator 42): 762 (Observation Room)

Notes

- This measure does not attempt to capture observation services exhaustively. Because current coding does not allow data to be obtained on comparable observation services from facility-based and professional claims, a more restrictive approach was chosen, recognizing that not all observation services will be captured, but that data reported will be more comparable.
- UB-92 revenue codes 760 and 769 should not be included. Although some observation room stays may be coded with these revenue codes, other visits and services not classified as observation room stays would be captured.
- Observation stays with a principal diagnosis of mental health and chemical dependency should not be reported in this measure. Mental health and chemical dependency services are reported in tables 5J to 5O.

Template Table 5E-1: Ambulatory Care: Medicaid

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

	Outpatient Visits (Excludes MH/CD)		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
Age	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Procedures	Procedures/1,000 Member Months	Stays	Stays/1,000 Member Months
<1								
1-9								
10-19								
20-44								
45-64								
65-74								
75-84								
85+								
Unknown								
Total								

Template Table 5E-2/3: Ambulatory Care: Commercial and Medicare Risk (reported separately)

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

	Outpatient Visits (Excludes MH/CD)		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
Age	Visits	Visits/1,000 Members	Visits	Visits/1,000 Members	Procedures	Procedures/1,000 Members	Stays	Stays/1,000 Members
<1								
1-9								
10-19								
20-44								
45-64								
65-74								
75-84								
85+								
Unknown								
Total								

INPATIENT UTILIZATION — NONACUTE CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *Age stratification is more detailed for children and members age 65 years and older, to account for demographic characteristics of the Medicaid and Medicare risk populations.*

Description

This table summarizes utilization of nonacute inpatient care in the following facilities: hospice, nursing home, rehabilitation, SNF, transitional care and respite. These data excludes mental health and chemical dependency.

Specifications

Calculation:

Medicaid: Tables 5F-1a, 5F-1b, 5F-1c and 5F-1d are constructed using Table 5F-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days, Days/1,000 Member Months and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5F-2a, 5F-2b and 5F-3 are constructed using Table 5F-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days, Days/1,000 Members per Year and Average Length of Stay for members in the payer group that the table addresses.

Nonacute Care is defined as:

➤ UB-92 Type of Bill code (Form Locator 4):

Hospice = codes 81X or 82X

OR

SNF = codes 21X or 22X

OR

Hospital transitional care, swing bed or rehabilitation = code 18X, where "X" represents any third digit.

OR

➤ UB-92 Revenue codes (Form Locator 42):

Hospice = codes 115, 125, 135, 145, 155, 650 or 659

OR

Rehabilitation = codes 118, 128, 138, 148, 158

OR

Respite = code 655.

OR

➤ Other nonacute care facilities that do not use the UB-92 for billing (ICF, SNF, etc.).

Include data from any institution that provides long-term/specialty nonacute care. Each plan should identify the appropriate codes.

Template Table 5F-1: Inpatient Utilization — Nonacute Care: Medicaid

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

Template Table 5F-2/3: Inpatient Utilization — Nonacute Care: Commercial and Medicare risk (reported separately)

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges/1,000 Members	Days	Days/1,000 Members	Average Length of Stay
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

DISCHARGE AND AVERAGE LENGTH OF STAY — MATERNITY CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *At-home deliveries should not be counted in this measure.*
- ➤ *Medicaid HEDIS age stratification has been adopted.*
- ➤ *In addition to Discharges and Days, health plans will report the following for vaginal and Cesarean section deliveries: Discharges/1,000 Member Months and Days/1,000 Member Months for Medicaid members and Discharges/1,000 Members per Year and Days/1000 Members per year for commercial members.*

Description

This table summarizes utilization information on maternity-related care for enrolled females who had live births during the reporting year. This information is reported for total deliveries, vaginal deliveries and Cesarean section deliveries.

Specifications

Calculation:

Medicaid: Tables 5G-1a, 5G-1b, 5G-1c and 5G-1d are constructed using Table 5G-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days, Days/1,000 Member Months and Average Length of Stay for female members in the Medicaid eligibility category that each table addresses.

Commercial: Tables 5G-2a and 5G-2b are constructed using Table 5G-2 as a template. Report Discharges, Discharges/1,000 Members per Year, Days, Days/1,000 Members per Year and Average Length of Stay for female members in the payer group that each table addresses.

Note: *Plans often use several sources to ensure the completeness and validity of live-birth information. Codes used for this table are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone, while others are used to supplement the plan's search to identify live births (e.g., V codes may be used alone; CPT-4 procedure codes are used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

Note: *Plans should document the percentage of their maternity population that was hospitalized in jurisdictions that have mandated (a) minimum covered length(s) of stay for maternity, for vaginal and cesarean section deliveries. Specify the minimum length(s) of stay.*

Total Deliveries Resulting in Live Births

Plans should identify all live births delivered in an inpatient setting and at birthing centers. At-home deliveries are not counted in this measure. In calculating the length of stay, both pre-delivery and post-delivery days are included. Birthing center deliveries are counted as one day of stay. Count multiple births as one delivery.

The sum of Cesarean sections and vaginal deliveries should equal this total.

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Cesarean Section

Identify Cesarean section deliveries using:

DRG codes: 370-371. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM procedure codes: 74.0-74.2, 74.4, and 74.99 or CPT-4 codes 59510, 59514, 59515, 59618, 59620 and 59622 in conjunction with one or more of the following ICD-9-CM diagnosis code or V codes:

ICD-9-CM code: An ICD-9-CM diagnosis code of 650.

OR

V codes: A V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the health plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

Vaginal Delivery

DRG codes: 372-375. Only deliveries resulting in live births should be included.

OR

ICD-9-CM codes: This is a residual category. It equals those discharges remaining after removing Cesarean sections from the total deliveries that result in live births.

Note: CPT-4 procedure codes 59400, 59409 59410, 59610, 59612 or 59614 in conjunction with an appropriate ICD-9-CM diagnosis code may be used to identify vaginal deliveries. Only vaginal deliveries resulting in live births should be included.

Template Table 5G-1: Discharge and Average Length of Stay — Maternity Care: Medicaid

Age	Female Member Months
10-14	
15-19	
20-34	
35-49	
Other*	
Total	

Age	Discharges	Discharges/1,000 Female Member Months	Days	Days/1,000 Female Member Months	Average Length of Stay
Total Deliveries					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Vaginal Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Cesarean Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

* "Other" includes females age 0-9, 50+ and of unknown age.

Template Table 5G-2: Discharge and Average Length of Stay — Maternity Care: Commercial

Age	Female Member Months
10-14	
15-19	
20-34	
35-49	
Other*	
Total	

Age	Discharges	Discharges/1,000 Female Members	Days	Days/1,000 Female Members	Average Length of Stay
Total Deliveries					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Vaginal Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Cesarean Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

* "Other" includes females age 0-9, 50+ and of unknown age.

CESAREAN SECTION RATE AND VAGINAL BIRTH AFTER CESAREAN SECTION RATE (VBAC-RATE)

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *Medicaid HEDIS age stratification has been adopted.*
- ➤ *Calculation of the C-Section rate is required.*
- ➤ *The measure Vaginal Birth After Cesarean Section Rate (VBAC Rate) is not required for the 1996 reporting year. It is being deferred because of the persistent problems with the identification of numerator and denominator for this rate from administrative data sources. Health plans should develop a method to track VBACs and repeated Cesarean Sections, e.g., utilizing the newly introduced CPT-4 codes 59610-59622. This measure will be required for the 1997 reporting year.*

Description

These tables summarize utilization information (Days, Average Length of Stay) for female members having a Cesarean section resulting in a live birth or giving vaginal birth to a live newborn during the reporting year after a prior Cesarean section. The C-Section rate and the VBAC rate are calculated.

Specifications

Calculation: Tables 5H-1a, 5H-1b, 5H-1c and 5H-1d for Medicaid members and Tables 5H-2a and 5H-2b for commercial members should be constructed using Table 5H as a template.

Cesarean Section Rate

This table can be completed by transferring data from the Discharge and Average Length of Stay — Maternity Care measure, and calculating the C-section rate.

The C-section rate is:

Denominator: Number of women who had a delivery (vaginal or Cesarean section) resulting in a live birth during the reporting year.

Numerator: Number of women who had a C-section resulting in a live birth during the reporting year.

Rate of Vaginal Deliveries after Cesarean Section (VBAC Rate)

To identify Vaginal Birth after Cesarean Section use the following:

ICD-9-CM diagnosis code of 654.2x (where x equals any fifth digit) or CPT-4 codes 59610, 59612 or 59614, in conjunction with one or more of the following ICD-9-CM diagnosis code or V codes:

ICD-9-CM code: An ICD-9-CM diagnosis code of 650.

OR

V-codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the health plan to document live births. The plan must document the method, including codes used, for validating live births.

DRG codes are not applicable in calculating VBAC rate.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

Note: *CPT-4 codes 59400, 59409 or 59410 may be used in conjunction with the ICD-9-CM diagnosis codes listed above, or with V-codes V27.0, 27.2, V27.3, V27.5 or V27.6 to verify live births.*

The VBAC rate is:

Denominator: Number of women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year and who had a previous C-section.

Numerator: Number of women who had a vaginal delivery resulting in a live birth during the reporting year and who had a previous C-section.

Note: *Plans should look as far back as possible for previous C-sections. Either administrative data or medical records may be used.*

Template Table 5H: Cesarean Section Rate and VBAC Section Rate: Medicaid and Commercial (reported separately)

Age	Discharges: Cesarean Deliveries	Days	Average Length of Stay	Discharges: Total Deliveries	C-Section Rate
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

Age	Discharges: Vaginal Deliveries with Prior C-Section	Days	Average Length of Stay	Discharges: Total Deliveries with Prior C-Section	VBAC Rate
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

* "Other" includes females age 0-9, 50+ and of unknown age.